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Optometry Coding & Billing Alert

ICD-10: Help Make Sense of Your Eye Care Claims With 'Z' Codes

These diagnoses can support screenings and much more.

Remember the 'V' codes that you frequently reported in the days of ICD-9? Following the transition to ICD-10, hopefully you're getting to know the 'Z' codes just as well, because these codes not only provide supplemental information on your claims, they could actually be the key that tells payers why they should reimburse you for your services. The Z codes are, in fact, important elements to correct coding practices.

The Z code category is formally referred to as "Factors influencing health status and contact with health services" in the ICD-10-CM Guidelines and code manual. The following tips can help ensure that you're using Z codes properly at your eye care practice.

Some Z Codes Can Be Listed As Primary Dx

Many coders are hesitant to use the Z codes as primary codes on their claims, but this is perfectly acceptable in many cases, says **Dee Mandley, RHIT, CCS, CCS-P**, president of D. Mandley & Associates, LLC in Stow, Ohio. "There are a few Z codes that can only be used as first-listed diagnoses. These are listed in the ICD-10-CM Official Guidelines for Coding and Reporting Section 1; C; 21; 16, found at https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2016-ICD-10-CM-Guidelines.pdf."

These include Z01.00 (Encounter for examination of eyes and vision without abnormal findings), Z01.01 (Encounter for examination of eyes and vision with abnormal findings), and Z02.4 (Encounter for examination for driving license), among others.

'Paint the Picture' With Z Codes

In other cases, when the Z codes aren't your primary diagnoses, you'll simply list them after your primary diagnosis codes to give the insurer a complete profile of what your patient is dealing with, Mandley says. "A coder will always want to code all codes necessary to 'paint the picture' for why the patient is being seen."

The reason for this is because the Z codes give the insurer additional information that may offer reasons why the doctor needed to report a higher-level E/M service, perform procedures, or order diagnostic workups. "It is appropriate to code all diagnoses that co-exist at the time of the visit that affect patient treatment or management this includes status conditions (Z codes)," says **Matthew Menendez**, vice president of sales and marketing with White Plume Technologies. "As always, make sure documentation supports your coding."

For example, if your patient presents for an eye exam but mentions that she recently found out she is pregnant and tells you she had gestational diabetes during her previous pregnancies, the optometrist may spend more time examining her eyes for any vascular symptoms that might be indicative of retinopathy. In this situation, you might use Z86.32 **(**Personal history of gestational diabetes) as a secondary diagnosis code.

Providers should specify which conditions and/or situations that they want to report in terms of additional Z codes, says Mandley. "If there are conditions that are being used for reports and/or statistical analysis, then there should be a specific 'in-house' coding guideline written so it clear what codes are expected to be reported," she advises.

In situations when a payer requires you to report a Z code such as Z88.0 (Allergy status to penicillin) to justify a more expensive antibiotic, then the payer should provide this in writing and your office should keep this information in its internal coding guidelines, Mandley says. "I would caution against coding every little situation (such as history of right

hip replacement) when the patient is being seen for diabetic retinopathy, as this takes extra time and would affect productivity."

Document Everything

As with all other codes, never report a Z code unless your documentation reflects the condition that the Z codes describe. For example, suppose your insurer allows Z83.511 (Family history of glaucoma) as a payable code for fundus photography (92250). If you're using that code, you must ensure that the patient's records include a documented history of glaucoma in the family.

"If a payer allows the family history code as a payable diagnosis, it should be satisfactory to have the family history documented in the patient's medical record," Menendez says. Keep in mind, however, that what one payer allows as a payable diagnosis might not be the same as what a separate insurer might cover.

If the patient's insurer does cover services performed due to family histories of certain conditions as payable diagnoses, you should ask the payer for the coverage decision so you can prove where it's allowable. "It would be helpful to get a copy of this requirement from the payer for the provider's coding compliance manual," Mandley says.